MDR: M4-02-3436-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 04/17/01 through 09/20/01.
   b. The request was received on 05/15/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution dated 05/14/02
   b. HCFAs-1500
   c. EOBs
   d. Letter to Compliance and Practices dated 06/12/02
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II: No carrier responses

3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of additional information submitted by the requestor on 06/19/02. The insurance carrier did not submit a response to the additional information. The MR-100 letter, notifying the carrier that a medical dispute was submitted, was mailed to the carrier by TWCC on 05/22/02. The "No Information Found" is reflected in Exhibit II in the Commission's case file.

4. Notice of Additional Information Submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services
   "Dr. ___ again re-billed for these services in addition to the dates of services through 7/17/01, pointing out that this was a Texas Workers' Compensation claim and that neither 'Contracted' nor 'Non-Contracted Provider' were applicable.
   Upon reconsideration, ___ again reduced Dr. ___'s usual and customary fee to $0.00:
   1) Code 00850 - 'Is necessary for this service/supply. ORIGINAL RECOMMENDATION IS CORRECT.'
   2) Code 00111 - 'Contracted Provider'
   3) Code 00850 - 'Supply has been increased due to a reconsideration adjustment'

4) No code noted on the EOB
Dr. ___ objects to (TPA) use of the above stated denial codes as the basis of their denials. These codes are **not** recognized by TWCC and are **not** in accordance with TWCC Rule 133.304(c). These codes are not found on the TWCC-62 (7/2000)."

2. Respondent: No Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 05/01/01 through 09/20/01. Dates of service 04/17/01 through 04/30/01, 05/14/01 CPT code 97010, and 07/30/01 CPT code 97537 will be addressed in the Dismissal Section of this Findings and Decision.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $3,903.00; the amount paid is $119.00; the amount in dispute is $3,784.00. Because the dates of service, 04/17/01 through 04/30/01 are being dismissed and the Table of Disputed Services was updated based on a telephone call with the provider representative on 10/22/02, the corrected amount in dispute is $3,160.00; the corrected amount paid by the carrier is $138.00; the corrected amount in dispute is $2,948.00.

3. The carrier denied the billed services by codes:
"*00850 IS NECESSARY FOR THIS SERVICE/SUPPLY. ORIGINAL RECOMMENDATION IS CORR [sic] ECT.";
"*00111 01 – CONTRACTED PROVIDER";
"*00850 /SUPPLY HAS BEEN INCREASED DUE TO A RECONSIDERATION ADJUSTMENT";
"*00111 02 – NON-CONTRACTED PROVIDER."
The provider submitted a letter to Medical Review Division and Compliance and Practices with notification that the carrier "is denying or reducing payment for health care services without properly responding to request for reconsideration." Those dates of service without EOBs will be addressed as fee disputes.

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
09/18/01	97018	$40.00	$0.00	F	$16.00	MFG MGR (I) (A) (9) (a) (ii); (10) (a); CPT descriptor	Medical documentation indicates the service was rendered in accordance with the MFG MGR. Reimbursement in the amount of **$16.00** is recommended.

09/18/01	97110 97530 97039	$98.00 for 2 units $122.00 for 2 units $44.00	$0.00	F	$35.00 per 15 unit $35.00 per 15 unit DOP	MFG MGR (I) (A) (9) (b); (10) (a); CPT descriptor MFG MGR (I) (A) (9) (c); (10) (a); (11) (b); CPT descriptor MFG MGR (I) (A) (9) (a) (iii); (9) (b); (10) (a); CPT descriptor	Recent review of disputes involving one-on-one CPT codes by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of these codes both with respect of the one-on-one documentation reflecting that these individual services were provided as billed. The Medical Review Division has reviewed the matters in light of the Commission requirements for proper documentation. 97110: The provider's medical documentation notes, "Therapeutic exercises for 2 15 minute intervals were used to develop strength, endurance, range of motion, and flexibility." The provider failed to identify the exercises and document the duration of each exercise. (The dispute packet contained no Flow or Activity Sheets). There is no direct statement as to who was conducting the activity with the patient or that the activity was being conducted on a one-on-one basis as per the MFG MGR. The documentation does not indicate any medical conditions or symptoms as to why the one-on-one supervision activities were mandated for the patient for the entire session or over an entire course of treatment. The documentation submitted by the provider does not reflect the need for one-on-one supervision tapering off over time as the patient became more familiar with the exercises. The documentation was not signed. 97530: Medical documentation does indicate a one-on-one activity, but does states "2 15 minute intervals with the use of dynamic activities were used to improve functional performance." The provider failed to identify the exercises and document the duration of each exercise. (The dispute packet contained no Flow or Activity Sheets). There was no direct statement as to who was conducting the activity with the patient. The documentation does not indicate any medical conditions or symptoms as to why the one-on-one supervision activities were mandated for the patient for the entire session or over an entire course of treatment. The documentation submitted by the provider does not reflect the need for one-on-one supervision tapering off over time as the patient becomes more familiar with the exercises. The documentation was not signed. 97039: Medical documentation states, "Fluidotherapy for 1 15 minute interval". The provider fails to document a direct statement that the activity was conducted on a one-on-one basis and who was performing the activity per the MFG MGR. The documentation does not indicate any medical conditions or symptoms as to why the one-on-one supervision activities were mandated for the patient for the entire session or over an entire course of treatment. The documentation submitted by the provider does not reflect the need for one-on-one supervision tapering off over time as the patient became more familiar with the exercises. The documentation was not signed. No reimbursement is recommended.

09/20/01	97035	$37.00	$0.00	F	$22.00	MFG MGR (I) (A) (9) (a) (iii); (10) (a); CPT descriptor	Medical documentation indicates the service was rendered. This service is always conducted as a one-on-one, just by the nature of the activity, but the provider failed to report the one-on-one status in the note submitted in the dispute packet. The provider states in the note, "Ultrasound for 1 15 minute interval". There is no direct statement as to who was conducting the activity and the documentation was not signed. No reimbursement is recommended.
09/20/01	97039	$44.00	$0.00	F	DOP	MFG MGR (I) (A) (9) (a) (iii); (9) (b); (10) (a); CPT descriptor	Medical documentation states, "Fluidotherapy for 1 15 minute interval". The provider fails to document a direct statement that the activity is conducted on a one-on-one basis and who is performing the activity per the MFG MGR. The documentation does not indicate any medical conditions or symptoms as to why the one-on-one supervision activities were mandated for the patient for the entire session or over an entire course of treatment. The documentation submitted by the provider does not reflect the need for one-on-one supervision tapering off over time as the patient becomes more familiar with the exercises. The documentation is not signed. No reimbursement is recommended.
Totals		$385.00	$0.00				The Requestor **is** entitled to reimbursement in the amount of **$16.00.**

V. RATIONALE

Medical Review Division's rationale:

Rule § 134.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)…" The carrier failed to submit explanation of benefits for dates of service 05/01/01, 05/02/01, 05/08/01, 05/09/01, 05/12/01, 05/14/01 (with the exception of CPT code 97010 which will be dismissed), 07/17/01, 07/30/01 (with the exception of CPT code 97537 which will be dismissed), 07/31/01, 08/16/01, 08/24/01, 08/30/01, 09/04/01, 09/06/01, 09/11/01, and 09/13/01 which included the correct payment exception codes required by the Commission's instructions or provide the provider with sufficient explanation to allow the provider to understand the reasons for the denials.

The provider billed CPT codes for these dates of service above the MAR values or by DOP values. The carrier failed to meet the standards set forth in § 134.304 (c), therefore, the provider will be reimbursed the MAR and DOP values for the dates in dispute. Reimbursement in the amount of $1,926.00 is recommended for the above referenced dates of service in dispute.

The above Findings and Decision are hereby issued this 23rd day of October 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $1,942.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 23rd day of October 2002.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division

CO/dmm

VII. Dismissal

Date of service 04/17/01, 04/18/01, 04/23/01, 04/25/01, 04/26/01, 04/30/01, and 05/14/01 (CPT code 97010 only) are being dismissed. According to Commission Rule 133.307 (m) (5), "The Division may dismiss a request for medical dispute, if: the Commission determines that good cause exists to dismiss the request."

Commission Rule 133.307 (e) requires, "…All provider and carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission….(1) Each initial request shall be legible, include only a single copy of each document, and shall include: (A) a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304;". The requestor failed to submit copies of Request for Reconsideration HCFAs for the dates of service in dispute, 04/17/01, 04/18/01, 04/23/01, 04/25/01, 04/26/01, 04/30/01, and 05/14/01 (CPT code 97010 only).

Commission Rule 133.307 (m) (5) also applies to date of service 07/30/01, CPT code 97537 only. Code 97537 is not an approved TWCC CPT code according to the Medical Fee Guideline, therefore, cannot be recognized by TWCC.

This dismissal does not constitute a decision on these dates of service.